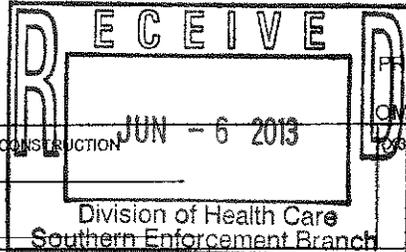


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 05/31/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/16/2013
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NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728
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F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	<p>A standard health survey was conducted on 05/14-16/13. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>An abbreviated survey (KY20183) was also conducted at this time. The complaint was substantiated with deficient practice identified.</p> <p>483.13(c)(1)(II)-(III), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p>	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda Williams TITLE: Administrator (X6) DATE: 6/6/2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and review of facility policy, it was determined the facility failed to thoroughly investigate an allegation of abuse and failed to report the allegation of abuse as required for one of twenty sampled residents (Resident #9). On 04/26/13, Resident #9 reported to facility staff an allegation of possible abuse that reportedly occurred on 04/25/13. The facility conducted an investigation on 04/26/13 into the allegation; however, a review of the facility's investigation revealed the facility had not interviewed the alleged perpetrator and as a result failed to conduct a thorough investigation and failed to report the allegation to the State Survey Agency and Adult Protective Services as required.</p> <p>The findings include: Review of the facility's Abuse policy (dated 02/05/03) revealed the alleged perpetrator would be informed of the allegation and a statement would be obtained from the alleged perpetrator as part of the facility investigation. The policy noted</p>	F 225	<p>Continued from page 1</p> <p>The Administrator interviewed Resident #9 at 8:30am regarding the allegation. She changed her report from nurse aide #1 being the ring leader to nurse aide #3 was the one.</p> <p>Administrator asked why she hadn't reported the incident the day before she stated "I don't know, I guess I didn't think about it." On reviewing the schedule to see who worked on 4/25/13 and 4/26/13, the nurse aides were correct. Nurse aide #3 was off when the incident was suppose to have happened as well as the day reported therefore we did not call her in but talked with her when she returned to work. Nurse aide #4 was the caregiver for Resident #9 both days. Resident #9 stated she was not afraid of the nurse aides and did not want them to stop providing care for her or her roommate. After conferencing with the rest of the staff on the first floor, we determined that the incident could not have happened as alleged and therefore did not report to OIG nor Adult Protection.</p> <p>All allegations of abuse will be reported to the Director of Nursing, Administrator, the OIG, Adult Protection and the police department immediately.</p> <p>Continue to next page</p>	

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F 225	<p>Continued From page 2</p> <p>allegations of abuse would be reported to "all agencies as required."</p> <p>Review of the medical record revealed the facility admitted Resident #9 on 08/11/06 with diagnoses including Diabetes Mellitus, Cerebral Degeneration, Dementia, and Coronary Artery Disease. On 02/26/13, Resident #9 was readmitted to the facility following hospitalization with new diagnoses of Delirium and Paranoid Behavior.</p> <p>Review of the comprehensive assessment dated 03/05/13, revealed the facility assessed Resident #9 to exhibit no symptoms of delirium and no symptoms of psychosis, including delusions, during the assessment reference period. In addition, the facility assessed the resident to exhibit rejection of care 1-3 days during the reference period. Resident #9's BIMS (Brief Interview for Mental Status) score was coded as 10 (moderate impairment with cognition).</p> <p>During the initial facility tour conducted on 05/14/13, at 10:45 AM, Resident #9 told the surveyor he/she was afraid of two nurse aides. The resident stated that a few days ago the nurse aides told the resident they were going to put a pillow over the resident's head and smother the resident. Resident #9 stated he/she had reported this concern to the nurses when the incident occurred but could not recall the specific date.</p> <p>Review of the Grievance/Complaint Report for Resident #9, dated 04/26/13, revealed that allegations that the day shift staff attempted/threatened to smother Resident #9 were reported to the Director of Nurses (DON) at</p>	F 225	<p>Continued from page 2</p> <p>The alleged staff member or members will be removed from Resident care until the investigation has been completed.</p> <p>In-services were conducted on 5/22/13, 5/23/13, and 5/24/13 to ensure all staff members understand the abuse policy and will report immediately regardless of any previous unsubstantiated allegations.</p> <p>An in-service was conducted by the Corporate Nurse Consultant on 6/5/13 for the Administrator and Director of Nursing to review the abuse policy and to ensure all allegations of abuse are reported to the appropriate agencies timely regardless of the facilities findings.</p> <p>The Administrator, Director of Nursing and Social Service Director will alternate visiting Resident #9 daily x 1 month to ensure the Resident feels safe.</p> <p>The Quality Assurance Committee will review monthly any complaints or allegations of abuse to ensure all reports and follow ups are completed timely.</p>	6/15/13

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F 225	<p>Continued From page 3</p> <p>5:00 AM on 04/26/13 by telephone. According to the report, the DON instructed the 11:00 PM to 7:00 AM shift nurse to document the incident and the investigation would be continued when she (DON) arrived at the facility later that day. The report dated 04/26/13 noted the grievance/complaint was not resolved due to the resident having a history of delirium and paranoid behaviors.</p> <p>Review of the facility investigation revealed interviews had been conducted with two of the Certified Nurse Aides (CNAs) who were working with Resident #9 on the date the incident was alleged; however, there was no evidence the facility had interviewed the alleged perpetrator (CNA #1). In addition, there was no evidence the facility reported the allegation to the appropriate state agencies.</p> <p>Interview with the Social Services Director (SSD) on 05/15/13, at 3:05 PM, revealed the Administrator was responsible to conduct the investigation and to report allegations of abuse to the state agencies. The SSD stated if the Administrator was not available then she or the DON would be responsible. The SSD stated she was aware of the allegation, but she did not receive the initial report and was not responsible to conduct the investigation or report the allegation to the state agencies. According to the SSD, a meeting had been conducted on 04/29/13 with administrative staff and the resident's daughter, and a psychiatric evaluation was suggested by the facility. According to the report, the resident's daughter preferred to wait until the resident had completed antibiotics for treatment of a urinary tract infection before consulting the</p>	F 225			

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F 225	Continued From page 4 psychiatrist. Interview with the Director of Nursing (DON) on 05/16/13, at 5:25 PM, revealed the DON was informed of the allegation by the night shift nurse on 04/26/13. The DON stated the alleged perpetrator (CNA #1) was scheduled off work on 04/26-27/13 and no interview was conducted with CNA #1 because, as a result of the facility's investigation, the facility did not suspect abuse had occurred. Interview with the facility Administrator on 05/16/13, at 5:30 PM, revealed she was also the facility's Abuse Coordinator. The Administrator stated based on the resident's history of paranoia and staff and family interviews, she did not believe the allegation occurred, did not feel the allegation was reportable, and acknowledged she had not interviewed the alleged perpetrator and failed to report the allegation to the State Survey Agency and Adult Protective Services in accordance with facility policy and regulations.	F 225			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F 280	A care plan was updated on Resident #9 to include interventions for allegations that staff are trying to kill her. The interventions included talking in a calm manner and assure of safety in facility, psychiatric consults as ordered, always have two staff in room when providing care of her and roommate, reassure about her safety, investigate any accusations and follow up as indicated. Nursing assistant care plan updated to report any behaviors to nurse and to have two people in room for all care. Continue to next page		

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F 280	<p>Continued From page 5</p> <p>disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop a plan of care when a change in condition was identified for one of twenty sampled residents (Resident #9). Review of the medical record and staff interviews revealed Resident #9 verbalized frequent accusations against facility staff; however, the facility failed to develop a plan of care to address these accusations.</p> <p>The findings include:</p> <p>Interview conducted with the Social Services Director (SSD) on 05/16/13, at 12:00 PM, revealed the facility did not have a policy related to the development and/or revision of the resident care plan. The SSD stated the Interdisciplinary Care Team followed the Resident Assessment Instrument (RAI) process to develop, revise, and update the care plans.</p> <p>Review of the medical record revealed the facility admitted Resident #9 on 08/11/06 with diagnoses including Diabetes Mellitus, Cerebral</p>	F 280	<p>Continued from page 5</p> <p>An audit was conducted by Social Services and Director of Nursing to ensure other residents had updated care plans for interventions for behaviors. Director of Nursing re-educated nursing staff May 22, 2013 on importance of updating care plans to assure consistent care and to provide interventions for behaviors. The nurses were re-educated on completing an acute care plan with any changes in care the Resident may have. On May 22, 23 and 24, 2013 a nursing assistant meeting was conducted to re-educate nursing assistants on importance of following care plan. The Director of Nursing also re-educated on the importance of notifying their nurse if they do not see any interventions in place for any Resident that may have behaviors. The Director of Nursing has a monthly meeting with each nursing unit to review care plans and insure care plans are updated. (One hallway per week.)</p> <p>Social Service runs a report weekly to assure behaviors that are documented by nursing assistants are also addressed by nursing care plan. Social Services will conduct this audit weekly x 1 month and then as Quality Assurance deems necessary.</p> <p>All audit results will be presented to Quality Assurance and will continue until Quality Assurance deems the practice corrected. Pre-care conferences will continue to be conducted weekly, as this is a routine process.</p>	6/15/13	

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F 280	Continued From page 6 Degeneration, Dementia, and Coronary Artery Disease. On 02/26/13, Resident #9 was readmitted to the facility following hospitalization with new diagnoses of Delirium and Paranoid Behavior. Review of the nurse's progress notes dated 04/30/13, at 5:50 AM, revealed Resident #9 accused facility staff of lying about the resident and being "crazy." On 05/03/13, at 9:30 AM, the nurse's progress notes revealed the resident had paranoid delusions and told the nurse the Unit Coordinator had instructed one of the Maintenance staff members to "have his way with the resident." Further review of the nurse's progress notes dated 05/04/13, at 5:00 PM, revealed Resident #9 had made "slurs" about a nurse aide during a conversation regarding taxes. On 05/11/13, the documentation revealed Resident #9 reported a nurse aide was talking to a man and asked the man if he had a gun. The man responded "yes" and the nurse requested the man to kill Resident #9. Interview with the SSD on 05/16/13, at 9:50 AM, revealed she was responsible to develop a care plan to address any problems related to mood, cognition, and behavior for the residents. The SSD stated she was aware of the repeated staff accusations made by Resident #9 and believed they were a result of the resident's paranoia; however, she had not developed a plan of care to include interventions or measures to address these accusations.	F 280			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281			

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F 281	<p>Continued From page 7 must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of quality for two of twenty sampled residents (Residents #3 and #17). Residents #3 and #17 had physician's orders for oxygen to be administered at 2 liters per minute; however, observations conducted on 05/14/13 and 05/15/13 revealed facility staff failed to ensure the oxygen was administered as ordered by the physician.</p> <p>The findings include:</p> <p>A review of the facility policy related to following physician's orders revealed that oxygen therapy was to be administered as ordered by a physician. The policy further noted the physician's order would specify the rate of flow of oxygen.</p> <p>A review of the medical record revealed the facility admitted Resident #3 on 11/23/11 with diagnoses that included Type II Diabetes, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, and Prostate Cancer. A review of the May 2013 physician's orders revealed the physician ordered oxygen to be administered at 2 liters per nasal cannula for Resident #3.</p> <p>Record review on 05/15/13 revealed facility staff</p>	F 281	<p>All residents receiving oxygen including Resident #3 and #17 were checked to ensure oxygen was set at the appropriate liters per minute.</p> <p>Staff nurses were made aware of the deficiency and reminded to check their Residents oxygen settings every shift and every time they entered the Residents rooms.</p> <p>Stickers were placed on concentrators relaying the amount of oxygen the Resident was to receive according to the physicians orders. SRNA's and the Housekeeping Department were reminded to check the readings when they entered the room to ensure that the concentrators were set on the appropriate liters, and to report to the nurse in charge of any discrepancies.</p> <p>In-services were conducted with the nurses on 5/22/13, SRNA's 5/22/13, 5/23/13 and 5/24/13 and Housekeeping Staff on 5/17/13 regarding the deficiency and reminded to observe the concentrators for appropriate settings.</p> <p>Residents receiving oxygen therapy were added to the SRNA's care plans with appropriate settings according to the physicians order with directions to report to the nurse in charge of any discrepancy.</p> <p>Continue to next page</p>		

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F 281	<p>Continued From page 8</p> <p>from the first, second, and third shifts had signed the Medication Administration Record (MAR) on 05/14/13 and 05/15/13 to indicate Resident #3's oxygen was being administered at 2 liters per minute via nasal cannula. However, observations conducted on 05/14/13 at 10:30 AM, 12:20 PM, and 3:37 PM revealed Resident #3 was lying in bed and oxygen was being administered at 4 liters per nasal cannula. On 05/15/13 at 8:50 AM, the resident was observed to continue to receive oxygen at 4 liters per nasal cannula.</p> <p>Interview conducted with Registered Nurse (RN) #2 on 05/15/13, at 10:50 AM, revealed she was assigned to provide care to Resident #3 on 05/14/13 and 05/15/13. RN #2 stated nurses were responsible to check the resident's oxygen setting at least one time during a shift.</p> <p>Interview conducted with RN #2 on 05/15/13, at 10:50 AM, revealed she had also been assigned to Resident #3 on 05/14/13, and stated she had checked Resident #3's oxygen setting to ensure the correct amount was administered to the resident.</p> <p>Interview with the Director of Nurses (DON) on 05/16/13, at 5:55 PM revealed nurses were responsible to check each resident's oxygen setting at least once per shift and when entering resident rooms during med pass or when providing direct care.</p> <p>2. Review of the medical record revealed the facility admitted Resident #17 on 07/19/10 with diagnoses including Cerebral Atrophy, Chronic Obstructive Pulmonary Disease, and Congestive Heart Failure.</p>	F 281	<p>Continued from page 8</p> <p>Resident #3's wife and caregivers were Educated regarding the use of oxygen and requested to ask the nurse to set the oxygen at the proper liters per minute.</p> <p>The Unit Coordinators were directed to spot check daily Residents receiving oxygen to ensure they were set on the appropriate readings according to physicians orders.</p> <p>The Quality Assurance Committee will assign the Administrator and the Director of Nursing to make random checks weekly to ensure Residents are receiving the appropriate amount of oxygen as prescribed by the physician.</p>	6/7/13	

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F 281	Continued From page 9 Review of the May 2013 physician's orders revealed oxygen was to be administered to Resident #17 at 2 liters per minute per nasal cannula. However, observations of Resident #17 on 05/16/13, at 2:10 PM and at 3:40 PM, revealed the resident was in bed and was receiving oxygen per nasal cannula at 3 liters per minute. Interview conducted with RN #2 on 05/16/13, at 4:10 PM, revealed she had provided care to Resident #17 on 05/16/13 and was responsible to check the resident's oxygen settings at least one time during her shift. The RN stated she had observed Resident #17 during the morning of 05/16/13 when the resident was in the dining room and noted the resident was receiving oxygen at 2 liters per minute per portable oxygen tank. However, the RN stated she had not checked the resident's oxygen setting after the resident was back in his/her room to ensure the oxygen was at the setting ordered by the physician.	F 281			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323	The threshold was replaced in the doorway of room #118 covering the chipped tile. All doorways were checked to ensure that they were safe and in good repair. In-services conducted on 5/22/13 for Nurses, 5/22/13, 5/23/13 and 5/24/13 for SRNA's and 5/22/13 for House-keeping Department included review of our policy regarding logging any needed Continue on next page		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/16/2013
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42726		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 10</p> <p>by:</p> <p>Based on observation and interview it was determined the facility failed to ensure the resident environment remained as free of accident hazards as possible. A doorway to resident room 118 was observed to have a missing threshold and uneven and chipped tile. Doors to the activity storage room and the oxygen supply room on the West Wing of the second floor were observed unlocked on 05/14/13.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. A review of the facility's Maintenance Repairs policy, dated 03/08/12, revealed all Departments were responsible for reporting any needed repairs and, in the event the needed repair was a safety hazard, the Maintenance Department would be notified immediately. <p>Observations conducted during the initial tour on 05/14/13 at 10:05 AM and on 05/16/13 at 1:00 PM revealed the threshold was missing from the doorway of resident room 118 and the tile was chipped and uneven.</p> <p>An interview conducted with the Maintenance Director on 05/16/13 at 1:00 PM revealed the resident room doors were checked monthly and the Maintenance Director made rounds weekly to identify concerns in need of repair; however, he was not aware of the missing threshold.</p> <ol style="list-style-type: none"> 2. An interview conducted with the facility Administrator on 05/15/13 at 1:30 PM revealed the facility did not have a policy regarding locking the Activity Storage Room and the Oxygen Supply Room. However, according to the Administrator, 	F 323	<p>Continued from page 10</p> <p>repairs in the Maintenance Log located at each nurses station and to report any safety hazards immediately to the Maintenance Department and the Administrator.</p> <p>The Housekeeping Supervisor and the Maintenance Director will conduct weekly checks to ensure all areas of the building are safe and in good repair. The Administrator will randomly check Maintenance Log and 25% of rooms Weekly to ensure the repairs have been completed or identified.</p> <p>In-service on 5/22/13 with the staff nurses included emphasis on responsibility to keep the oxygen room closet, Activity storage room, and the medical supply room locked at all times.</p> <p>Automatic closures were applied to the medical supply room, the oxygen supply room and the Activity storage room.</p> <p>Automatic locks will replace the existing locks on these doors. Until they have been replaced, the doors will be checked every shift by the nursing supervisor to ensure they remain locked.</p>	6/15/13	

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F 323	Continued From page 11 the doors should be locked when no one was in the rooms. Observations conducted during the initial tour of the West Wing of the second floor on 05/14/13 at 10:00 AM revealed the Activity Storage Room contained an unlocked Intravenous Therapy Cart with intravenous (IV) needles, tubing, and fluids. Further observation during the tour of the West Wing of the second floor revealed an unlocked oxygen supply room which contained tanks of stored oxygen. Observations conducted on the West Wing on 05/14-15/13 revealed no evidence of wandering residents; however, a review of a list of residents who were assessed by the facility to wander revealed the West Wing of the second floor had one wandering resident who lived on the West Wing.	F 323			
F 371 SS=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of facility policy, the facility failed to ensure foods	F 371	When the Administrator was informed of the problem with the food carts the meal service was stopped and the cook was instructed to return to the kitchen to reheat the food. Residents who had been served were asked if their food was cold or would like something else and they declined stating the fried chicken was good. Apologies were made to those who's lunch was delayed. All Residents were monitored for twenty four hours for symptoms of nausea, diarrhea or vomiting. No symptoms were noted. Continue on next page		

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F 371	<p>Continued From page 12</p> <p>served from the buffet serving cart met safe temperatures to prevent foodborne illness for nine residents, observed at random, that received ground chicken. Observation of the tray assembly in the large first floor dining room on 05/14/13 at 12:15 PM revealed the dietary staff failed to connect the buffet cart to a power source in order for the cart to become operational and to maintain food temperatures at the proper safe holding temperatures of 135 degrees Fahrenheit (F) when served from the buffet tray line. On 05/14/13 at 12:15 PM, the Dietary Cook checked the temperatures of the foods on the buffet table and found the ground chicken was held at 120 degrees F. The Dietary Cook continued serving the ground chicken to the nine residents observed at random without consulting the Dietary Manager for further instructions or replacing the chicken.</p> <p>The findings include:</p> <p>A review of the facility's undated policy on temperature control holding revealed the dietary staff was to maintain temperatures of potentially hazardous foods at 135 degrees F or 57 degrees Celsius (C).</p> <p>A review of the 2009 Food Code 3.501.16 revealed: Except during preparation, cooking, or cooling the time/temperature control for food safety will be maintained with an internal temperature of 135 degrees F or 57 degrees C.</p> <p>Observation conducted on 05/14/13 at 12:15 PM of the tray assembly in the large first floor dining room revealed the dietary staff did not connect the buffet cart to a power source and, as a result,</p>	F 371	<p>Continued from page 12</p> <p>All Residents charts were reviewed for any symptoms of nausea, diarrhea or vomiting for the previous two weeks. No symptoms occurred.</p> <p>The meal carts were taken out of commission until they were repaired. 5/20/13 A service man from Commercial Refrigeration checked the meal carts and calibrated the temperatures as needed</p> <p>Intervention was put in place to return to the old system with food carts brought to the dining room while the meal carts were out of commission.</p> <p>The policy on delivery of food was reviewed and updated to include checking temperatures of the food on the cart every fifteen minutes while serving. The cooks have been instructed to log the temperatures and to report to the Dietary Manager and Administrator immediately of any inappropriate temperatures.</p> <p>An in-service was provided on 5/22/13 by the Dietician, Dietary Manager and the Administrator to review the deficiency and to review policies, procedures and disciplinary measures that will be enforced for failure to abide by the policies.</p> <p>Continue on next page</p>		

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F 371	<p>Continued From page 13</p> <p>the buffet cart was not heated in order to maintain food temperatures at a safe holding temperature.</p> <p>On 05/14/13 at 12:15 PM (ET), the Dietary Cook was observed to check the temperatures of the foods on the buffet cart and found the ground chicken was held at 120 degrees F. The Dietary Cook continued serving the chicken to nine residents and failed to replace and/or consult with the Dietary Manager for further instructions.</p> <p>An interview conducted 05/14/13 at 2:35 PM with the Dietary Cook that had served the ground chicken from the buffet cart revealed the heating element off/on switch on the buffet cart had not been working for "two weeks or longer." The Dietary Cook stated that both buffet carts were not working but the dietary staff was instructed by the facility Dietitian to continue to utilize the carts for dining room food distribution and tray assembly. A review of the Food Temperature Record for the lunch meal on 05/14/13 revealed the food temperatures met the standard temperatures at 140 degrees F. However, the facility Dietary Cook stated the temperatures were checked in the facility kitchen prior to placing the foods on the food cart. The Dietary Cook stated the internal temperatures of the foods assembled for dining room distribution were obtained before being placed in the buffet cart and were not checked during distribution to ensure the foods remained at the acceptable temperatures required.</p> <p>An interview was conducted with the facility Dietary Manager (DM) on 05/16/13 at 12:30 PM (ET) and revealed the DM had contacted the</p>	F 371	<p>Continued from page 13</p> <p>The dietary staff was instructed to report to the Maintenance Supervisor and the Administrator when any dietary equipment is not working properly.</p> <p>The Dietary Manager will report to the monthly Quality Assurance Committee any problems with food temperatures or facility dietary equipment.</p>	6/7/13	

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F 371	Continued From page 14 facility Dietitian to confirm the current process would be adequate for serving/holding food temperatures of foods served to residents in the dining room. An interview conducted with the facility's consultant Dietitian on 05/16/13 at 9:30 AM (ET) revealed the Dietitian had not directed the dietary staff to continue to utilize the buffet cart to hold/serve residents in the dining rooms. An interview was conducted with the facility's Maintenance Supervisor on 05/16/13, at 11:45 AM (ET). The facility's Maintenance Supervisor stated the buffet had malfunctioned in April 2013 and a new part for the buffet had been ordered and replaced at that time. The Maintenance Supervisor stated he was unaware that the off/on button on the buffet had stopped working again until 05/08/13 and stated new parts had been ordered to repair the buffet. An interview was conducted with the Administrator on 05/14/13 at 4:30 PM (ET) and revealed staff had failed to report to her that the buffet carts were not functioning properly. According to the Administrator, the DM should have reported that the buffet carts were not functioning properly. The Administrator also acknowledged staff had failed to monitor/record the food temperatures on the buffet carts.	F 371			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431	The Novolin 70/30 Insulin for Resident D was discarded as was the Latanoprost Ophthalmic drops for Resident C. New medications were started and dated 5/17/13. Continue on next page		

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F 431	<p>Continued From page 15</p> <p>accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, Interview, review of the Centers for Disease Control (CDC) guidelines, and review of facility policies/procedures, it was determined the facility failed to ensure medications for resident use were labeled and dated appropriately. Review of the CDC</p>	F 431	<p>Continued from page 15</p> <p>Medication drawers were checked on 5/17/13 by the Nursing Supervisors to ensure all medications requiring beginning dates were in fact dated.</p> <p>Nursing in-service on 5/22 /13 reviewed deficiency and responsibility for each nurse to date new vials of Insulin and eye drops When first opening a new vial or bottle.</p> <p>The Unit Coordinators have been instructed to check the medication drawers weekly to ensure all Insulins and eye drops are dated timely.</p> <p>The Director of Nursing will spot check medication drawers monthly to ensure all medications are dated appropriately.</p> <p>The Quality Assurance Committee will review the Unit Coordinators and Director of Nursing's findings during the monthly meeting to ensure medications are dated appropriately.</p>	6/7/13	

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F 431	<p>Continued From page 16</p> <p>guidelines revealed if a multi-dose vial of medication had been opened or accessed, the vial should be dated and discarded within 28 days from the date the vial had been opened (unless the manufacturer specifies a different date). One multi-dose vial of Novolin 70/30 insulin and two bottles of eye medications were observed on the West Wing medication cart to be opened, not dated as to when they had been opened, and were available for resident use.</p> <p>The findings include:</p> <p>Review of the facility policy/procedure, "Medication Storage in the Facility," (dated 02/01/10) revealed medications should be stored following the manufacturer's recommendations. However, the policy did not include specific directions for storage and labeling of medications.</p> <p>Review of the CDC guidelines for storage and handling of multi-dose vials of medications revealed if a multi-dose vial had been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial.</p> <p>Observation of the West Wing medication cart on 05/16/13, at 6:30 PM, revealed an opened and undated multi-dose vial of Novolin 70/30 Insulin for Resident D that was available for resident use. In addition, a bottle of Latanoprost Ophthalmic drops for Resident C was opened and not dated, and a bottle of Timolol 0.5% ophthalmic drops was opened and not dated for Resident E.</p> <p>Interview on 05/16/13, at 6:30 PM, with Licensed</p>	F 431			

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F 431	Continued From page 17 Practical Nurse (LPN) #2 revealed all multi-dose vials/bottles should be dated when opened and discarded after 28 days. According to LPN #1, all facility staff nurses were responsible to monitor the medication storage to ensure medications were dated when opened for resident use. Interview conducted with the Director of Nurses (DON) on 05/16/13, at 6:45 PM, revealed all multi-dose medication vials/bottles should be dated and initialed when opened. The DON stated all nursing staff was responsible to monitor the labeling of medications during medication administration.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	The nurse who failed to follow our policy regarding disinfecting the blood glucose monitor with appropriate cleaner was conferenced and placed on probation for three months. She will be randomly observed during medication pass and will be terminated for failure to follow infection control policies should the error be repeated. The Unit Coordinators have been instructed to randomly observe two staff nurses during medication pass each week to ensure all infection control procedures are being followed. Continue to next page		

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F 441	<p>Continued From page 18</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to establish and maintain an infection control program designed to provide a safe and sanitary environment to prevent the transmission of disease and infection for two of twenty sampled residents and five unsampled residents (unsampled Residents A and B). Facility staff failed to disinfect a blood glucose monitoring device according to facility policy, manufacturer's recommendations, and Centers for Disease Control (CDC) guidelines between use for unsampled Residents A and B.</p> <p>The findings include:</p> <p>A review of the facility's Cleaning and Disinfection of Resident Care Equipment policy, with an effective date of 11/01/12, revealed resident care equipment would be cleaned and disinfected</p>	F 441	<p>Continued from page 18</p> <p>The Director of Nursing provided an in-service to the licensed nurses on 5/22/13 to review infection control policies, responsibilities and disciplinary measures that will be enforced for failure to follow policies.</p> <p>The Quality Assurance Committee will review infection control reports at each monthly meeting and will determine the necessity for implementing more frequent observation during medication pass.</p>	6/7/13	

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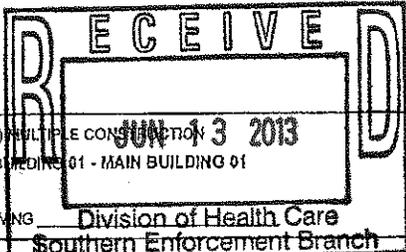
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F 441	<p>Continued From page 19</p> <p>according to current CDC recommendations and reusable resident care equipment would be disinfected between residents according to manufacturer's instructions.</p> <p>A review of the Manufacturer's Guidelines for the blood glucose monitoring device revealed the manufacturer suggests the device be disinfected with an environmental protection agency approved germicidal wipe (i.e. PDI Super Sani Cloth) or a 1:10 bleach solution.</p> <p>A review of the CDC guidelines for infection prevention during blood glucose monitoring, updated 03/02/12, revealed blood glucose monitoring devices should be cleaned and disinfected according to manufacturer's recommendations after every use.</p> <p>Observation of blood glucose monitoring for Resident A conducted on 04/15/13 at 5:00 PM revealed Licensed Practical Nurse (LPN) #3 cleaned a blood glucose monitoring device with alcohol swabs and entered Resident A's room to check the resident's blood glucose level. LPN #3 cleaned the resident's finger with alcohol and was stopped by the surveyor prior to performing the procedure.</p> <p>An interview conducted with LPN #3 on 04/15/13 at 5:00 PM revealed the LPN was trained to disinfect the blood glucose monitor with bleach wipes between resident use. According to LPN #3, she "panicked" and did not use the bleach wipes because they were not on the cart. The LPN stated she thought the alcohol wipes were just as effective to disinfect the blood glucose monitoring device. Further interview with LPN #3</p>	F 441			

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F 441	<p>Continued From page 20</p> <p>revealed she had also used alcohol to disinfect the blood glucose device for Resident B on 04/15/13 prior to attempting to use the device on Resident A.</p> <p>A review of facility training for LPN #3 revealed the LPN was trained regarding the disinfecting of resident equipment during orientation on 02/20/13.</p> <p>An interview conducted with the Director of Nursing (DON) on 05/16/13 at 1:45 PM, revealed the facility used manufacturer's recommendations regarding disinfecting the blood glucose meters between resident use and the facility provided bleach wipes of a 1:10 concentration and Super Sani Cloth wipes to disinfect the blood glucose monitoring devices between resident use.</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two story, Type 11(000)</p> <p>SMOKE COMPARTMENTS: 6</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detection</p> <p>SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system</p> <p>GENERATOR: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 05/15/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The census on the day of the survey was 97 with a bed capacity of 104.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p>	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda Williams TITLE: Administrator (X6) DATE: 6/6/2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/15/2013
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728	
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K 029	<p>Continued From page 1</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were protected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one of six smoke compartments.</p> <p>The findings include:</p> <p>Observation on 05/15/13 at 2:14 PM, revealed the storage room door near the Second Floor Nursing Station was not equipped with a self-closer. Further observation revealed combustible materials (cardboard boxes) were being stored in the room. Storage rooms containing combustible materials must have doors equipped with self-closers to prevent the spread of fire. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 05/15/13 at 2:14 PM, with the</p>	K 029	<p>A self closure was placed on the medical supply door to prevent the spread of fire in the event one should happen.</p> <p>The Maintenance Director checked all storage room doors containing combustible materials to assess the need for additional self closures.</p> <p>In-services on 5/22,23 and 24/2013 included review of the Maintenance Log located at each nurses station and to report any safety hazards immediately to the Maintenance Department and the Administrator. Staff was educated regarding necessity of self closure doors to prevent the spread of fire.</p> <p>The Housekeeping Supervisor and the Maintenance Director will conduct weekly checks to ensure all areas of the building are safe and in good repair. The Administrator will randomly check Maintenance Log and 25% of rooms weekly to ensure the repairs have been completed or identified.</p> <p>In-service on 5/22/13 with the staff nurses included emphasis on responsibility to keep the oxygen room closet, Activity storage room and the medical supply room locked at all times.</p> <p>Continue to next page</p>	

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K 029	Continued From page 2 Maintenance Director, revealed he had not identified the door as needing a self-closer before the annual survey. Reference: NFPA 101 (2000 Edition). One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	Continued from page 2 Automatic closures were applied to the medical supply room, the oxygen supply room and the Activity storage room. Automatic locks will replace the existing locks on these doors. Until they have been replaced, the doors will be checked every shift by the nursing supervisor to ensure they remain locked	5/28/13
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that exit doors with a magnetic locking device with delayed-egress hardware had letters on the sign that indicated 'PUSH UNTIL ALARM SOUNDS' and 'DOOR CAN BE OPENED IN 15 SECONDS' that were not less than 1 in. (2.5 cm) high for	K 038		

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K 038	<p>Continued From page 3</p> <p>seven of eight exterior exit doors with delayed-egress locks. The deficiency had the potential to affect 104 residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 05/15/13 at 2:58 PM, revealed the exterior exit door for the near Dietary office had a magnetic locking device with delayed-egress hardware. Observation revealed a sign on the door that indicated a delayed function operation (PUSH UNTIL ALARM SOUNDS and DOOR CAN BE OPENED IN 15 SECONDS) had lettering that measured less than 1 in. (2.5 cm) high. Further observations revealed the same for the exterior exit doors for the 100 Hall, the 200 Hall, and the Front Lobby. Doors equipped with delayed egress hardware must have signage of the proper height indicating the proper function for releasing the door in an emergency.</p> <p>Interview on 05/15/13 at 2:58 PM, with the Maintenance Director revealed the facility had the signs made by a local sign shop and was not aware that all doors equipped with delayed locking devices required a sign with letters that had a minimum height of 1 in. (2.5 cm).</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>7.2.1.6.1. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with</p>	K 038	<p>The Maintenance Director checked all exit doors to assess need for ordering one inch letters to comply with the Life Safety Code.</p> <p>The old half inch letters were replaced with one inch letters on all exit doors.</p> <p>The Maintenance Department was educated regarding the Life Safety Code Standard and will check all exit doors weekly to ensure the signs are maintained.</p> <p>The Administrator will make monthly rounds to ensure the signs are maintained and in good repair.</p>	5/22/13

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NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
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K 038	<p>Continued From page 4</p> <p>Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, re-locking shall be by manual means only.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS Actual NFPA Standard: NFPA 101, 19.2.2.2.2. Locks shall not be permitted on patient sleeping room doors.</p> <p>Exception No. 1: Key-locking devices that restrict access to the room from the corridor and that are operable only by staff from the corridor side shall</p>	K 038			

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K 038	Continued From page 5 be permitted. Such devices shall not restrict egress from the room. Exception No. 2: Door-locking arrangements shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that keys are carried by staff at all times	K 038		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure complete sprinkler coverage was provided according to National Fire Protection Association standards. The deficiency had the potential to affect one of six smoke compartments, 32 residents, staff, and visitors. The findings include:	K 056		

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NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 409 BOMAR HEIGHTS COLUMBIA, KY 42728	
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K 056	<p>Continued From page 6</p> <p>Observation on 05/15/13 at 3:44 PM revealed the storage room on the East Wing was not equipped with a sprinkler head. Further observation revealed a walk-in freezer had been installed blocking the original sprinkler head. All areas must be equipped with sprinkler protection to prevent the spread of fire. The observations were confirmed with the Maintenance Director.</p> <p>Interview on 05/15/13 at 3:44 PM, with the Maintenance Director, revealed he had not identified the area as needing sprinkler protection before the survey.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception:* Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.</p> <p>Table 19.1.6.2 Construction Type Limitations</p>	K 056	<p>5/17/13 Roger Basil with Fire Guard Sprinkler Service was contacted to make the necessary repairs to the sprinkler head.</p> <p>The Maintenance Staff checked all storage rooms to ensure that they provided appropriate sprinkler protection.</p> <p>The Administrator will make monthly rounds with the Maintenance Director to visually check sprinkler heads to ensure that in the event of a fire all areas of the building are well covered.</p> <p>An arm extension was added to the sprinkler head in the East Wing storage room to ensure adequate sprinkler protection.</p>	6/11/13

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K 056	<p>Continued From page 7</p> <table border="1"> <thead> <tr> <th>Construction Type</th> <th>1</th> <th>2</th> <th>3</th> <th>4</th> </tr> </thead> <tbody> <tr><td>I(443)</td><td>X</td><td>X</td><td>X</td><td>X</td></tr> <tr><td>I(332)</td><td>X</td><td>X</td><td>X</td><td>X</td></tr> <tr><td>II(222)</td><td>X</td><td>X</td><td>X</td><td>X</td></tr> <tr><td>II(111)</td><td>X</td><td>X*</td><td>X*</td><td>NP</td></tr> <tr><td>II(000)</td><td>X*</td><td>X*</td><td>NP</td><td>NP</td></tr> <tr><td>III(211)</td><td>X*</td><td>X*</td><td>NP</td><td>NP</td></tr> <tr><td>III(200)</td><td>X*</td><td>NP</td><td>NP</td><td>NP</td></tr> <tr><td>IV(2HH)</td><td>X*</td><td>X*</td><td>NP</td><td>NP</td></tr> <tr><td>V(111)</td><td>X*</td><td>X*</td><td>NP</td><td>NP</td></tr> <tr><td>V(000)</td><td>X*</td><td>NP</td><td>NP</td><td>NP</td></tr> </tbody> </table> <p>X: Permitted type of construction. NP: Not permitted. *Building requires automatic sprinkler protection. (See 19.3.5.1.) 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5.</p>	Construction Type	1	2	3	4	I(443)	X	X	X	X	I(332)	X	X	X	X	II(222)	X	X	X	X	II(111)	X	X*	X*	NP	II(000)	X*	X*	NP	NP	III(211)	X*	X*	NP	NP	III(200)	X*	NP	NP	NP	IV(2HH)	X*	X*	NP	NP	V(111)	X*	X*	NP	NP	V(000)	X*	NP	NP	NP	K 056		
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